Equitable and Adequate Reimbursement Methodology for Medicaid Inpatient Psychiatric Care Report

(FY2020 Appropriation Act -- Public Act 166 of 2020)

September 30, 2021

Sec. 1513. *(1) The department shall participate in a workgroup to determine an equitable and adequate reimbursement methodology for Medicaid inpatient psychiatric hospital care. The workgroup shall include representatives from the department, CMHSPs, PIHPs, the Michigan Association of Health Plans, the Michigan Health and Hospital Association, inpatient psychiatric facilities, Blue Cross Blue Shield of Michigan, the Community Mental Health Association of Michigan, and other individuals or organizations as determined appropriate by the department.*

(2) By September 30 of the current fiscal year, the workgroup shall report to the senate and house appropriations subcommittees on the department budget, the senate and house fiscal agencies, the senate and house policy offices, and the state budget office on the implementation of recommendations made by the workgroup required by section 1513 of 2019 PA 67. The report shall include, but is not limited to, the following: (a) Descriptions of the recommendations being implemented. (b) Descriptions of the recommendations not being implemented and barriers preventing implementation.

(3) The department shall assist in providing data to inform the workgroup discussion, assist in modeling appropriate reimbursement methods, and assist in developing the final report.

MDHHS

Michigan Department of Health & Human Services

Executive Summary

The Section 1513 Inpatient Psychiatric Workgroup was established to meet the goal of determining an equitable and adequate reimbursement methodology for Medicaid inpatient psychiatric hospital care. The workgroup began meeting in May of 2021. Meetings focused on reviewing reimbursement models and identification of factors most important for use in determining rates. Factors discussed included behavioral health, intellectual or developmental disability diagnoses, age, existence of both physical and behavioral health conditions, likelihood of violent behavior, and the need for one-on-one care. The group recommends creating a tiered rate structure with higher rates paid for pediatric patients, patients with potential for violent behavior and patients that require one-on-one care. Defining rate tier logic and determining payment amounts will be a focus for the workgroup in FY22, with a planned implementation for FY23.

Historical Background

Section 1513(2) PA 67 of 2019 required the department to establish a workgroup to determine an equitable and adequate reimbursement methodology for Medicaid inpatient psychiatric hospital care. The workgroup was to recommend a statewide per diem rate, which took several factors into consideration: patient severity, acuity, likelihood of violence, need for 1-1 care, presence of a developmental disability, etc. Because key stakeholders were focused on responding to the COVID-19 pandemic, Section 1513(2) PA 67 of 2019 deliverables were not completed in FY2020. MDHHS initiated activities and established the workgroup in FY21.

Michigan's Medicaid budget allocates approximately $2.8 billion annually to provide behavioral health supports and services. Of that, in FY2019 approximately $290 million was used to provide community inpatient and crisis services[1]. Self-determination and independent living models are core elements of the support and service system. While the primary focus in Michigan is enabling individuals to live in the least restrictive setting as possible, hospitals are a key component to provide care when a community-based setting is not appropriate to meet the level of care that is needed. Since 1996, Community Mental Health Service Programs (CMHSPs) have been responsible for screening and determining if an inpatient level of care is needed. In FY2019, nearly 230,000 inpatient days of care were provided to Medicaid and Healthy Michigan Plan enrollees at an average cost of $804 per day. Approximately 22,000 adults (21-64 years old) and 3,000 children (0-18 years old) received one or more days of Medicaid inpatient psychiatric care during FY2019. The Hospital Reimbursement Adjustment (HRA) psychiatric hospital payments started in FY2010 to partially cover the gap between Medicaid and Medicare reimbursement levels. The HRA provided an additional $45M annually to hospitals for psychiatric care provided to Medicaid beneficiaries, from FY2010 through FY2018. In FY2019 the annual amount increased when payment logic was revised to comply with CMS managed care rule requirements. In FY2020 psychiatric HRA payments totaled $87M.

[1] MDHHS Behavioral Health and Developmental Disabilities FY2019 Section 904 Report (2)(c), Fiscal Year 2019 CMHSP Services Gross Cost by Total Population, page 6. Report on CMHSPs, PIHPs, and Regional Entities, Per Section 904(1) of PA 67 of 2019 (michigan.gov)

Workgroup Process and Considerations

During FY2021, Section 1513 Inpatient Workgroup meetings focused on review of Michigan data, models used in other states and discussion of the most significant rate factors to be considered in the development of a tiered rate structure. In March a survey of all CMHSPs and PIHPs was conducted to gather data on current Medicaid PIHP/CMHSP contracted rates with hospitals for inpatient psychiatric care. The survey demonstrated a wide range of variability in current daily rates: the overall average adult bundled rate was $857 (average low/high of $677/$1233) and overall average child bundled rate was $816 (average low/high of $753/$858). These rates are primarily representative of the bundled per diem revenue code 0100. Some survey respondents commented on rate factors currently considered, including the need for one on one staffing and intensive care for children and adults with an intellectual or developmental disability. While some rates are currently set based on these factors, it is unclear to what extent each PIHP/CMHSP uses a methodology that distinguishes between lower and higher levels of service acuity. There is a lack of consistency in acuity adjustments to increase or decrease the standard per diem payment.

The workgroup reviewed several inpatient psychiatric payment models used in other states, as well as a model proposed by a workgroup member. Information was also presented on the Medicare Inpatient Psychiatric Facility Prospective Payment System. The following examples from select states were shared with the group:

1. Diagnostic related groups (DRG) case rate (payment per discharge): Minnesota Medicaid pays for inpatient psychiatric services under its all patients refined (APR) DRG methodology, and includes policy adjusters to enhance the base DRG payment for mental health-related APR DRGs.
2. Cost-based per diem rates: Washington Medicaid pays for inpatient psychiatric services using prospective per diem rates based on the hospital-specific average cost per day with a budget target adjustor applied, subject to a rate floor based on statewide averages.
3. Acuity-adjusted per diem rates: New York Medicaid pays for inpatient psychiatric services using per diem rates adjusted by the APR DRG relative weight and other factors (including a length of stay variable that reduces the per diem rate as the length of stay increases). This methodology mimics the Medicare Inpatient Psychiatric Facility Prospective Payment System (IPF PPS), with New York Medicaid-specific adjustments.

Most state Medicaid agencies use a per diem payment methodology, more specifically, cost-based per diem rates without an acuity adjustment[2]. A draft Henry Ford Health System model was presented as well. This model is based on 22 psychiatric diagnostic related groupings, each with further specified severity levels.

Workgroup discussions covered a number of factors that impact the cost of inpatient psychiatric care. These factors are listed in Table 1 below. Some workgroup members suggested creating a tiered rate structure based on diagnostic related groups (DRG) with comorbidity adjustments, and rate add-ons for pediatric patients, patients with violent behavior, and patients requiring one-on-one care. However, there is concern that the complexity of DRG and comorbidity adjustments may be a barrier for PIHP adoption--a greater degree of precision in a rate structure is likely more difficult to

[2] Based on the 2018 MACPAC study "States' Medicaid Fee-for-Service Inpatient Hospital Payment Policies" and independent research of New York Medicaid.

implement. Some workgroup members also recommended that a tier be determined during the preadmission screening process, with the ability for adjustment during the course of an inpatient stay.

TABLE 1

Factor	Description
All Patient Refined Diagnosis Related Group (APR-DRG) Weight Factor	All Psychiatric DRGs with four severity levels each. See factors from New York model.
Age-Adjustment Factor	Age 17 and under.
Comorbidity Factor (to address both physical and mental health)	Eighteen factors with various payment factors. See list from New York model.
Involuntary Stay Patient Factor	Involuntarily admitted patients. Court hearings for guardianship issues.
Violent Patient Factor	Known history of violence, aggression, or unpredictable behavior. Documented violence in the pre-admission environment. History of incarceration for a violent crime.
Intellectual or Developmental Disability Factor	Patients with an intellectual or developmental disability.
1-1 Care Factor	Patients who require 1-1 clinical care, for example, registered sex offenders.
State Bed Transfer Factor	Patients awaiting transfer to a state hospital.

Recommendations:

The workgroup has made progress toward the goal of determining an equitable and adequate reimbursement methodology for Medicaid inpatient psychiatric hospital care. A next step is to establish tiered rates with the workgroup's recommended goal of implementation starting FY23. As work moves forward, the challenge will be determining an appropriate level of precision and complexity. The development of the tiered rate structure will require coordination with MDHHS Medicaid Actuarial and the State Budget Office to ensure adequate funding for rate increases. Consideration should also be given to the existing Hospital Reimbursement Adjustment (HRA) psychiatric hospital payments. Additional implementation steps would include changes to the MDHHS contracts with the PIHPs to prepare for a tiered rate. Besides funding, another potential barrier to a FY23 implementation includes the time required to make downstream contract changes between the PIHPs/CMHSPs and hospitals in their provider networks.

Proposed Implementation Timeline:

1. By 11/12/21: Workgroup review of MI historic inpatient data, for example number of inpatient days, pediatric and adult patients, counts of those with coding indicating violent behavior.
2. By 12/17/21: MDHHS shares preliminary tiered rate combinations with workgroup.
3. By 1/31/22: PIHPs establish process for reporting violent behavior and provision of one-on-one care.
4. By 2/28/22: Workgroup recommends assessment tool to be used for tier assignment.
5. By 3/31/22: MDHHS/workgroup finalize rate combinations after consultation with MDHHS Medicaid Actuarial and the State Budget Office.
6. By 4/30/22: MDHHS to present PIHP contract changes to contract negotiation group.
7. By 7/1/22: PIHP encounters include reporting violent behavior and provision of one-on-one care.
8. 10/1/22: implementation of tiered rates for inpatient psychiatric care.
9. By 3/31/24: MDHHS/Milliman review of new rate structure impact toward intended goals.

Michigan Department of Health and Human Services

Section 1513 Inpatient Workgroup

FACILITATOR

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Meetings
(In Person/Teleconference)

1. *When:* **Wednesday, May 5, 2021**
   Where: Teams Meeting

2. *When:* **Wednesday, May 26, 2021**
   Where: Teams Meeting

3. *When:* **Wednesday, June 23, 2021**
   Where: Teams Meeting